Model Quality Improvement Reviews

Completed in 1998, these Model Quality Improvement Reviews, or focused study outlines, were designed for use by organizations providing integrated care. These reviews provide information to organizations about fifteen specific areas of care and service delivery (system level and direct service level) identified by BOTH providers and consumers as important to quality of care and quality of life. Specific review areas include: Identifying and Integrating Member/Caregiver Preferences into Care Planning and Evaluation, Transportation Systems, and Personal Care Services.

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Wisconsin Partnership Program

**Protocols for
Annual Quality Improvement Reviews
For Organizations Serving Frail Elderly, Chronically Ill Individuals and/or Individuals
with Physical Disabilities**

Contents:

A. Introduction/History

Attached are the Model Quality Improvement (QI) reviews designed to assist Partnership organizations serving frail, chronically ill and physically disabled populations to identify priorities for quality improvement studies.

These Model QI reviews are designed as guidelines for the development of ongoing quality systems. The purpose of the reviews is to provide information to health care providers and organizations in particular areas of care (system level and direct service) that were identified by experts and consumers as important to quality of care and quality of life. The quality improvement reviews should assist organizations and providers in improving the quality and design of existing care delivery systems.

The Model QI reviews are based on 3 years of research involving in-depth interviews with consumers and providers in order to gain a better understanding of how each of these groups view quality. These QI reviews integrate the perspectives of these two groups. Other guiding principles include:

- All enrollees, providers, and staff should be knowledgeable about the mission of the Partnership agency and strategies designed to accomplish the mission and goals.

- Enrollee involvement (or an enrollee's designated proxy or proxies when the enrollee is unable to participate or wishes proxy involved) in decsionmaking about their care wherever possible, to the greatest extent possible, is crucial. Enrollee ability to participate may change over time and setting and should be not be viewed as permanent

- Enrollee preferences, priorities, and perspective can be integrated with long term care and acute care standards of practice

- High quality, patient-centered care requires organizational systems designed to promote these goals

- Long-term care for frail, chronically ill and physically disabled individuals must be provided within a system that maximizes integration, smooth transition and follow through of care.

- The Partnership agency must be responsible for assuring that subcontractors are knowledgeable about the mission and goals of the program and have mechanisms needed to meet the standards of care set by the Partnership Program.

- All enrollees, staff and providers (including subcontracting agency staff), and family members should be involved in planning, implementation, and evaluation of Partnership agency services.

B. How To Read QI Review Outlines

Each Model QI Review contains comprehensive information. Each review should be viewed as a guideline for how a Partnership system of integrated care will eventually look. To conduct an initial QI review, the Partnership organization should select those items most relevant to the services they're providing and the goals they're trying to accomplish. No organization is expected to explore every indicator for the selected QI review.

If an organization selects a QI review for which they clearly have no system in place, then the first year review should focus on identifying the important components and designing the system to allow them to complete the review.

C. How to Use QI Review Outlines

Step 1:   Carefully read the **Assumptions**. Remember, these are based on extensive interviews with consumer and providers.

Step 2:   The **Target Population** usually includes 'All enrollees'. This does not mean that all enrollees must be reviewed. It means Partnership organizations must select, preferably at random, a preselected number of enrollees in their program. This should be a minimum of 15% of the total census or 25 enrollees, whichever number is less. If there is no system for randomly selecting enrollees for study, one should be developed as part of the current year QI review.

Step 3:   Carefully read the **Goal of Review**. It is important to understand why you are conducting the review and what is expected to be learned from the review.

I.   **If you discover you have no system in place to conduct the review**, then the current year goal will be to identify the necessary elements and design a system that will allow you to conduct the review. This will require the selection or development of data sheets to conduct chart reviews, interviews, reviews of organization policies/procedures/provider competencies, etc.. You may also discover that your medical records system will not allow you to retrieve the information you need. In this case, one of your goals for the current year will be to develop a medical records system that allows you to retrieve the data needed.

II. **If you discover there is a system in place related to the QI Review topic**, review the **Quality Indicators** provided. If these indicators are reflected in the current system, select 3-5 indicators for review. If these indicators are not reflected in the current organizational system, the goal for the current year will be to adapt the system to include the quality indicators identified.   It is assumed that the quality indicators identified in the Model QI reviews will be reflected in the data collection sheets designed and used by the organization.

Step 4:   Review the **Sources of Data** outlined for each QI review area. It is assumed that data collection sheet being used by the organization will draw on these data sources. Other sources of data should be reported as part of the QI review findings.

Step 5:   Conduct the review.

Step 6:   Report findings specific to each indicator
Identify areas where the agency is performing well.
Identify areas where the agency needs improvements.
Develop a plan to address areas where improvements are needed and/or a plan
to maintain/enhance areas where the agency is doing well.

1. Identification of and Integration of Member/Caregiver Preferences

Assumptions:

1. Consumer-centered care <u>requires</u> identification <u>and</u> integration of member quality of life and member <u>and</u> provider goals and preferences.

2. Members do not always express quality of life related concerns that are important to them, or their preferences about the organization and delivery of services, because they may be uncomfortable doing so and/or may not have the opportunity to do so.

3. Members often do not participate in individualized service plan (ISP) development because they may be uncomfortable doing so, may not have the opportunity to do so, or may be prevented from doing so.

4. For most chronically ill and/or physically disabled individuals, quality of life issues cannot be separated from the quality of care. Decisions made by health care providers have a direct impact on member quality of life.

5. Member perspectives and preferences may be different from, even inconsistent with, provider perspectives, preferences, and/or provider defined outcomes.

6. Member preferences regarding health care services and quality of life <u>must</u> be considered <u>together</u>. When this information is integrated into care planning, it should inform health and long-term care provider goals and may result in changing provider priorities.

7. A better understanding by providers of the relationship between services and member quality of life will result in a better outcome for the member

8. <u>Outcomes that reflect both member and provider goals may be different than outcomes reflecting only provider goals.</u> Both clinical standards/outcomes and member-defined quality of life <u>must</u> be documented, considered, and integrated in the ISP.

9. <u>Members and providers must participate actively in</u> <u>planning, implementing, and evaluation the quality of care and services</u>. This cannot be done in a single encounter or by a single provider – it requires a collaborative team effort.

A. <u>Target Population</u>: All members

B. <u>Goal of Review</u>:
I.   To discover whether there is a system in place to ensure that: member preferences,
          priorities, goals, and fears are:
          1) clearly identified,
          2) integrated into ISP development, <u>and</u>
          3) documented in the ISP

II. To discover whether that system works effectively by showing evidence of the following:

1.   **Identifying Member Preferences/Quality of Life Issues:**
        - Opportunities for and mechanisms by which members express their goals,
          preferences, and concerns to each IDT member, including personal care staff, prior
          to development of ISP and periodically afterwards
        - Opportunities for members to express their preferences in particular about:
            a) Primary care provider (including use of specialty provider)
            b) Personal care workers (see QI Review #9)
            c) Delegated decision maker(s)
            d) Intensity and duration of treatment
            e) Timing/scheduling, intrusiveness of interventions/treatment/care services
            f) Transportation systems (see QI Review #10)
            g) Place of residence
            h) Preferred community activities

2.   **Integrating Member Information Into ISP Development**
        - Opportunities during IDT meetings for discussion of Member concerns and
          discussion of how this information is integrated into decisionmaking about the
          organization and delivery of services
        - Opportunities for personal care staff to present Member information to IDT
          members on an ongoing basis
        - Conflicts or inconsistencies between preferences of member and providers are
          identified and addressed
        - Members' opportunity to participate in the development of ISP including
          decisions/choices about:
            a) Primary care provider (including use of specialty provider)
            b) Personal care workers (see QI Review#9)
            c) Delegated decision maker(s)
            d) Intensity and duration of treatment
            e) Timing/scheduling, intrusiveness of interventions/treatment/care services

       f)   Transportation systems (see QI Review #10)
       g)   Place of residence
       h)   Preferred community activities

- Members participation in decisionmaking about clinical outcomes, treatment, and service options
- Mechanisms in place that communicate and facilitate ISP (including member identified concerns) information across settings and providers

3.   **Evaluating ISP for Evidence of Integration**

- ISP reflects unique attributes, resources, preferences, biography, (including spirituality) of member
- ISP reflects progress made toward achieving member preferences including evaluations of progress with the member at predesignated intervals
- ISP documents conflicts or inconsistencies (and response) between preferences of member and providers
- ISP documents information provided to members to maximize understanding of possible outcomes
- ISP anticipated/desired outcomes reflect priorities identified by member and provider/system

C.   Data Sources.   Sources of data should include, but are not limited to:

     -ISP review
     -Relevant policies and procedures, in-services, provider competencies
     -Member/caregiver/care team interviews

2. Monitoring Medication Profiles to Anticipate and Prevent Medication-related Risks

Assumptions:

Many of the problems experienced by elderly enrollees are related to medications. Many of these problems can be minimized, possibly eliminated, by closer monitoring of medications. In some instances, this will result in changing medications. In other situations, it will lead to interventions designed to minimize risk by managing side effects.

A. Target Population.   All enrollees:

1) taking more than seven medications (prescription, OTC)
2) with more than two providers prescribing medications
3) using more than one pharmacy
4) with insufficient funds or benefit coverage for purchasing medications
5) with cognitive impairment
6) with history of ETOH use/abuse
7) taking medications for chronic pain, anxiety, depression, sleep disorders or high blood pressure
8) who are unable to read instructions on medication labels

B. Goal of Review:

I. To discover whether a system is in place to reduce risk to enrollees in selected subgroups of A (above).

II. To discover whether the system in place is effective by showing evidence of the following Quality Indicators:

1) Elimination of medications contraindicated in geriatric population
2) Eliminating/substitution of medications with side effects that increase risk of falls, confusion, constipation, depression
3) Accuracy of medication taking (financial resources, troublesome side effects, substitution monitoring)
4) Decreased sources of medications
5) Minimized risk through patient education, environmental alteration, identification and evaluation of incompatibility between patient choices and prescriptions (e.g., ETOH) with enrollee/caregiver
6) Enrollee (target population) understanding of medications and side effects for conditions leading to chronic pain, chronic anxiety and/or depression, sleep disorder, high blood pressure
7) Existence of a medication monitoring system to identify risk profiles
8) Documentation of identification of and follow through on high risk enrollees

9) Documentation of information provided to enrollee
10) Identification of conflicts or inconsistencies between preferences of enrollee and providers
11) Documentation of reliable medication taking plan for enrollees with cognitive impairment or multiple prescriptions

C. Data Sources.   Sources of data should include, but are not limited to:

-Chart review
-Relevant policies and procedures and provider competencies
-Enrollee/caregiver interviews

3. Transportation Systems

Assumptions: Transportation influences enrollee access to care, quality of care experiences, and overall quality of life.

A. Target Population: All enrollees using transportation systems designed for multiple users.

B. Goal of Review:

I. To discover whether there is a system in place to ensure that the transportation services meet the criteria for high quality services that have been identified by enrollee, caregiver, and provider groups.

II. To discover whether the system in place in working effectively by showing evidence of the following Quality Indicators

1) Accommodation of physical limitations of enrollees
2) Transit time less than ___
3) Waiting time less than ___
4) Transfer points less than ___
5) Maximum flexibility and predictability of scheduled services
6) Drivers meeting basic competencies
7) Consistency in drivers
8) Policies and procedures regarding driver supervision, evaluation and training
9) Driver training to provide service specific to population and particular enrollees
10) Driver self-evaluation on competency to drive population and specific enrollees
11) Enrollee evaluations of transportation service and specific driver (reliability, flexibility, respectful, competency)
12) Respectful, friendly, skilled drivers
13) Identification of conflicts or inconsistencies between preferences of enrollee, provider, and/or driver and that these have been addressed and documented

C. Data Sources.   Sources of data include, but are not limited to:

1. Scheduling policies and procedures
2. Driver training programs
3. Driver supervision and evaluation system
4. Interviews with enrollees and drivers
5. Transportation records

4. Physical, Occupational and/or Speech Therapy

Assumptions: Most rehabilitation policy allowances are based on short-term, reversible conditions and do not get adapted for individuals with long term, chronic conditions or conditions there is little known about.

A. Target population: Enrollees with chronic illness or permanent disability

B.   Goal of Review:
I. To discover whether there is a system in place to ensure that the structure of services and treatment programs reflect the needs of enrollees with long term or permanent illness and disability.
II. To discover whether the system in place is effective by showing evidence of the following Quality Indicators:

1) Usual criteria for rehabilitation and other services have been adapted for their relevance for enrollees with physical disabilities
2) Policies outlining limits on intensity, frequency, and duration of services have been adapted to accommodate the needs of the enrollee with physical disabilities
3) Policies outlining usual criteria of functional level attainment and other benchmarks have been adapted to accommodate the needs of the enrollee with physical disabilities
4) Enrollee perception of service adequacy has been documented
5) PCP's perception of match between service availability and enrollee need has been documented
6) Flexibility and alternative criteria are in place in care areas when adequate scientific documentation is not available
7) Identification of conflicts or inconsistencies between preferences of enrollee and providers and that these have been addressed and documented

C.   Data Sources. Sources of data include, but are not limited to:

1) Review policies regarding rehabilitation services for individuals with chronic illness or disability including: frequency, duration, eligibility
2) Review organization's policies on service limitation, eligibility, prior approval
3) Interviews with enrollees/caregivers/primary provider
4) Existence of special appeals process to consider requests for which there is not adequate scientific investigation to either approve or deny.

5. Hospitalization and Post Discharge Care Management

Assumptions: Experiencing a hospitalization puts older adults at increased risk for multiple problems. Many of these problems are preventable.

A. Target Population: All enrollees discharged from an acute care setting.

B. Goal of Review:

I. To discover whether there is a system in place to ensure continuity and coordination of care across settings.

II. To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators:

1) Enrollee and caregiver(s) participated in development of post-hospital POC for enrollee
2) Enrollee/caregiver understand post-discharge plan of care, possible complications, what to expect, and when to contact providers
3) Provider input and enrollee information is integrated/coordinated across settings
4) Enrollees at risk for fragmented care have been identified and monitored
5) Post-discharge plan of care specifically addresses the integration of pre- and post-hospitalization care
6) Relevant biographical and medical enrollee information is provided to acute care staff across settings
7) Hospital related risks for population were addressed preventably and following discharge
8) Increased resource needs were identified with enrollee/caregiver input and were provided in timely manner, maximizing patient preferences
9) Interdisciplinary care team staff involved in in-patient decisionmaking
10) Home visit occurs during first week post-discharge
11) Rehabilitation and other services to return enrollee to baseline condition have been provided
12) Conflicts or inconsistencies between preferences of enrollee and providers have been identified, addressed and documented

C.   Data Sources.   Sources of data should include, but are not limited to:

-Chart review of pre- and post-hospital care
-Enrollee/caregiver interview about post-discharge experience
-Relevant policies and procedures (including post-hospital follow-up plan)
-Formal contracts with other service sites
-Cross site plans of care

6.   Population-Specific Routine Screening and Prevention

Assumptions: Although screening prevention and health promotion are potentially beneficial for frail elderly, they are often not considered.

A.   Target Population.   All enrollees.   (The contracting agency is required to maintain documentation of routine screening and prevention for all enrollees.)

B. Goal of Review:

I. To discover whether there is a system in place to ensure that screening based on population and individual risk is carried out routinely

II. To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators:

1) Enrollee/caregiver(s) understand routine screening and risk factors
2) Documentation of individual enrollee participation in screening and prevention activities or reason for not participating.
3) Chart documentation that screening protocols are in use and up-to-date for individual enrollees
4) Routine use of health promotion programs
5) Identification and monitoring of risk factors
6) Correspondence between individual risk factors and screening prevention
7) Documentation of plan to address risk factors
8) Enrollee/caregiver actively participated in plan development
9) Identification of conflicts or inconsistencies between preferences of enrollee and providers and that these have been addressed and documented
10) Documentation of when screening/prevention procedures are contraindicated, redundant, not indicated, or refused

C.   Data Sources.   Sources of data include, but are not limited to:

-chart review
-protocols used for general screening, prevention, and health promotion
-relevant policies and procedures, provider competencies

7. Depression and Mood Disorder

Assumptions: Depression is a common, serious, and often treatable condition in the elderly. Despite this, depression often goes undetected and untreated. Depression compromises health and quality of life.

A.   Target Population: Enrollees who:
> Exhibit signs of depression including 3 or more of the following:
> 1) New or long-standing sadness (expressed or self/other reported)
> 2) Hypersomnolence, insomnia, or interrupted sleep
> 3) Restlessness or agitation
> 4) Irritability or anger
> 5) Social withdrawal
> 6) Indecisiveness
> 7) Sudden weight change without other explanation
> 8) ETOH and or drug use/abuse
>
> or exhibit signs of becoming depressed, including those with:
>
> 9) Recent changes in physical health or major treatment plan
> 10) Addition of medications known to cause depression
> 11) Recent loss of significant others including pets
> 12) Recent change in housing
> 13) Recent change in sensory status.

B. Goal of Review:
I. To discover whether a system is in place to ensure that assessment for existence, or risk of, depression is systematically assessed.
II. To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators:

1. Enrollee/caregiver(s) participation in plan of care for depression
2. Documentation of identification and treatment of enrollees exhibiting depression or at risk behavior
3. Documentation of follow-up of identified at risk enrollees
4. Documentation that prior to, or in addition to, pharmacological treatment, precipitating causes and circumstances and life issues (including life 'anniversary dates') are addressed with enrollee and caregivers
5. Documentation of enrollee coping strategies from past are identified and considered in management plan

6. Identification of conflicts or inconsistencies between preferences of enrollee and providers and that these have been addressed and documented
7. Appropriate individuals (including PCW, in-home caregiver) are knowledgeable in identifying signs/symptoms of depression

C. Data Sources.   Sources of data should include, but are not limited to:
-Chart review
-Relevant organizational policies and procedures and provider competencies
-Enrollee/caregiver interviews.

8. Constipation and Fecal Impaction

Assumptions: Constipation and fecal impaction are commonly occurring conditions in frail, chronically ill, elderly populations. These conditions have an impact on enrollee quality of life and are often preventable.

A. Target Population: Enrollees at risk include those with:

1) Sedentary lifestyle
2) Dietary risk including: low fiber diet, poor appetite, low fluid intake
3) Narcotic use
4) Repetitive laxative use
5) History of constipation or impaction
6) Diabetes.

B. Goal of Review:
I. To discover whether there is a system in place to ensure the identification of individuals at risk for, or experiencing, fecal impactions or constipation
II. To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators

1) POC for management of constipation/impaction reflects participation of enrollee/caregiver
2) Documentation in charts of high risk enrollees including a plan for preventive management including assessment of all items in (A)
3) Identification of conflicts or inconsistencies between preferences of enrollee and providers and that these have been addressed and documented
4) Evidence of follow through on plan and evaluation of success
5) Evidence of enrollee knowledge, participation in plan (chart and interview)
6) Evidence of staff training in identifying high risk enrollees as well as assessing and managing chronic constipation.

C. Data Sources. Sources of data include, but are not limited to:

1) Chart review for evidence of medical history relevant to high risk
2) Interview with high risk enrollees/caregiver(s)
3) Examination of medication profiles to identify high risk enrollees.

9. Personal Care Worker Program

Assumptions:

1. Personal care workers (PCWs) play a pivotal role in identifying Member quality of life and affecting the quality of care in multiple settings.

2. Personal care (PC) staff information is not always integrated into IDT decisionmaking

3. PC staff must be supported, well informed, and formally integrated into ISP development, care planning decisionmaking and evaluation.

A. Target Populations: All Members receiving personal care services and all personal care staff.

B. Goal of Review:
I. To discover whether there is a system in place to ensure high quality of personal care services from both provider and Member perspectives.
II. To discover whether the system in place is working effectively by showing evidence of the following:

1) PC staff have met agency competency requirements, including in-service orientation requirements, within ___ of hire and have been reevaluated as determined by agency
2) Supervision guidelines for PC staff have been implemented and are effective
3) Scheduling procedures have maximized Member choice and consistency in PC staff
4) Adequate backup systems, that minimize disruption to Member schedules, are in place
5) Opportunities for Member/caregiver participation, as appropriate, in PCW training and evaluation
6) A PC work environment that provides PC staff access to assistance from supervisor, or relevant other, while in the Member's home
7) PC staff participation in development of Member ISP
8) Opportunity for PC staff to evaluate agency support, supervision, backup, and training including whether PC staff
    feel supported in their work
    feel well-informed about their role and the work they do
    have access to supervision as needed
    feel that their supervisor is responsive

feel knowledgeable about what information to report to their supervisor/the IDT team

9) Opportunity for PC staff to evaluate PCW/Member match
10) Opportunity for Member to evaluate relationship with and skill of PC staff
11) Conflicts or inconsistencies between preferences of Member and PC staff have been evaluated, addressed and documented in the ISP
12) Agency personal care staff turnover rate is under 50%

C. Data Sources. Sources of data include, but are not limited to:

1) Chart/ISP review
2) Relevant policies and procedures including:
    - competency requirements
    - orientation program
    - in-service training program relevant to specific Member/PC staff match
    - supervision guidelines and procedures
    - scheduling procedures
    - back-up system for PC staff
3) Personal care staff turnover data
4) Interview with Member/caregiver, PC staff, PC supervisors

10. Falls With or Without Fracture

Assumptions: Falls are serious, often predictable, and often preventable in frail, chronically ill populations.

A. Target Population: Enrollees with history of falls or at risk of falls including   enrollees with:

1) General decreased muscle strength/general weakness
2) Impaired mobility, including (severe) arthritis
3) Orthostatic hypotension or taking medications known to cause falls
4) Foot lesions, deformities, or pain
5) Dizziness, vertigo, especially with impaired balance
6) Multiple sensory deficit, especially in combination with decreased mobility or impaired balance
7) ETOH and/or OTC drug abuse
8) Environmental hazards (checklist)
9) Evidence of physical abuse
10) Urinary incontinence (slippery floor)
11) Parkinson's (tremors)
12) Anemia
13) Dehydration

B.   Goal of Review:

I. To discover whether there is a system is in place to ensure that high risk enrollees are identified, and risk of serious injury from falls is minimized when it is not possible, appropriate, or desirable to eliminate the factors contributing to risk.

II To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators:

1) Identifications of enrollees at risk (see A. above)
2) Physical assessments to determine risk factors, and related, treatable, reversible causes have been completed
3) Enrollee/caregiver have actively participated in discussions about risk reduction, especially changes in enrollee environment/residence
4) Physical assessments of general muscle strength and specific muscle groups have been completed
5) plan for muscle strengthening has been Implemented whenever possible
6) Medications causing orthostatic hypotension have been eliminated whenever possible
7) Treatment of foot conditions have been completed
8) Provision of appropriate assistive devices have been made

9) Assessments of sensory functioning have been completed
10) Assessments of home environment to identify potential hazards have been completed
11) Conflicts or inconsistencies between preferences of enrollee and providers are identified, addressed, and documented.

C. Data Sources. Sources of data should include, but are not limited to:

-Chart review
-Relevant organizational policies and procedures and provider competencies
-Enrollee/caregiver (including PCW, family) interviews

11. Urinary Incontinence

Assumptions:
   Urinary incontinence is often seen by both enrollees and providers as normal aging and therefore assessment and management are often not pursued.
   Urinary incontinence often leads to social isolation and stress for both enrollee and family. Many elderly enrollees do not tell providers about problems with incontinence

A. <u>Target of Population at Risk.</u>   Enrollees with reported and unreported incontinence.

B.   <u>Goal of Review:</u>
I. To discover whether there is a system in place to ensure that all enrollees are given opportunity to report/reveal urine loss or urine control problems and that treatment potential has been determined for enrollees reporting incontinence.
II. To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators:

1) Strategies for increasing control of continence have been identified and tested
2) Medications that are known to exacerbate incontinence have been eliminated when possible
3) Enrollee and caregiver(s) participation in development of management plan for continence
4) Identification of health and social consequences of incontinence
5) Identification of conflicts or inconsistencies between preferences of enrollee and providers
6) Urinary continence assessments have been completed:
   * following hospitalization
   * in presence of increased caregiver stress
   * in presence of unexplained withdrawal from family/social activities
   * following addition of diuretics (or medications that tend to cause incontinence)
   * following decline in enrollee's mobility
7) Assessment on the impact of incontinence on the following has been completed
   a) skin integrity
   b) falls
   c) caregiver's stress
   d) depression
   f) self-perception

C. <u>Data Sources.</u>   Sources of data should include, but are not limited to:

-Chart review for incontinent enrollees and Random chart review to determine inclusion of continence assessment for all enrollees.
-Relevant policies and procedures and provider competencies
-Enrollee/caregiver interviews on knowledge, understanding, and impact of incontinence

12. Assistive Technology

Assumptions:
Assistive technology is often difficult to assess, access, acquire, and maintain.

Individuals with physical disabilities use assistive technology to engage in meaningful activities, maintain relationships, and be employed.

A. Target Population: All enrollees with assistive technology

B. Goal of Review: To discover whether a system is in place that identifies, purchases, maintains appropriate assistive technology in a timely manner.

C. Data Sources. Sources of data include, but are not limited to:

-Chart review
-Relevant policies, procedures, and provider competencies
-Providers, assistive technology staff expert, enrollee/caregiver interviews
-Purchase/repair documentation and training manuals
-Enrollee complaints documentation

D. Outcomes and findings.   The QI review looks for evidence of :

1) Enrollee/caregiver and staff expert is knowledgeable about available assistive technology
2) Enrollee/caregiver/staff have been trained in use of assistive technology
3) Choices in assistive technology meet enrollee-specific needs when possible
4) Documentation when enrollee chosen technology isn't purchased (reasons why)
5) Available expertise regarding the use/adaptation/repair of technology
6) Timeliness and quality of purchase and repair of assistive technology
7) Identification of conflicts or inconsistencies between preferences of enrollee and providers and that these have been addressed and documented
8) Availability of alternative technology while primary technology is being repaired

13.   Physical Environment and Access

Assumptions:

There are many environmental barriers to receiving high quality services in additional to physical access to the care setting. Effective communication, receipt of health care services, and interactions with health care providers are all a part of accessibility to quality care.

A.   Target population: All enrollees

B.   Goal of Review:

I. To discover whether there is a system in place that ensures environmental access to providers including physical access, comfort, and effective communication with providers.

II. To discover whether the system in place is working effectively by showing evidence of the following Quality Indicators:

> a)   Use of exam tables with adjustable height
> b)   Use of alternative to exam table when possible
> c)   Widened doorways in agency entrance, exam rooms and ancillary settings
> d)   Unobstructed entrances and hallways throughout agency and ancillary settings
> e)   Accessible bathroom in agency and ancillary settings
> f)   Automatic doors in agency and ancillary settings
> g)   Accessible waiting room in agency and ancillary settings
> h)   Handicapped parking at agency and ancillary settings
> i)   Ability of staff to lift/transfer enrollee in agency and ancillary settings
> j)   Accessibility to assistive technology for hearing impaired in agency and ancillary setting

C.   Data Collection.   Sources of data include, but are not limited to:

-Enrollee/caregiver/staff/provider interviews
-Direct observation of physical environment of care settings across sites
-Policies and procedures (including gynecological exam procedures), provider competencies, in-service/staff training on lifting, transfers, etc.

Model QI Review: Nutrition

Assumptions:

1. Nutritional problems of chronically ill and physically disabled individuals are often under-appreciated and under-treated and can lead to serious health consequences.

2. Illness, disability and multiple treatment regimes can all lead to nutrition problems in chronically ill and disabled populations.

3. Several risk factors can contribute to poor nutritional status:

   - social isolation -tooth and gum disease -pain (mouth and other)
   - chronic disease   -limited resources   -fatigue
   - medications   -limited ADLs/functional status -depression

4. Poor nutrition is a serious problem and can lead to:

   - compromised immune response/infection   -decubitis ulcers
   - weight loss/gain   -increased medication side effects
   - poor dental status   -confusion   -constipation
   - poorly healing wounds -fluid retention -nausea
   - lethargy/fatigue

A. Target Population: All members with two or more risk factors (in #3 above)

B. Goal of Review:

   I. To discover whether there is a system in place to ensure that:

   - there is a nutritional screening to identify those individuals at risk for poor nutritional status
   - there is an assessment of those individuals identified to be at risk
   - a plan to maximize nutritional status is established by the team including the member
   - the success of the plan is evaluated by the team and the member at predesignated intervals
   - adjustments to the plan are made as needed and in consultation with the member

   II. To discover whether that system works effectively by showing evidence of the following:
   - Nutritional risk is systematically identified and assessed
   - A plan to address nutritional risk is established by the team including the member

-The nutritional plan is evaluated systematically and revised in consultation with the member

-reassessment of members post plan implementation indicates evidence of nutritional risk reduction

C. Data Sources: Sources of data should include, but aren't limited to:

-ISP review

-relevant policies and procedures (including nutritional screening tools), in-services, provider competencies

-Member/caregiver/team interviews

Model QI Review: Chronic Pain Management

Assumptions:

1.   Unrelieved pain is a major, yet often treatable health problem.

2.   Individuals with chronic illness or physical disabilities often experience pain.

3.   Pain is what it is experienced to be. Subjective report is the best indicator of pain.

4.   Unrelieved pain can produce adverse physiological and psychological consequences including:

decreased bowel function	impaired immune function
decreased pulmonary function	sleeplessness
loss of appetite	impaired movement
anxiety and depression	feelings of helplessness or hopelessness
loss of mobility	loss of functional status

5.   Chronic pain impairs quality of life.

6.   Complete pain relief may not be possible, but it can often be managed.

7.   Both consumers and providers underestimate the ability to treat pain.

8.   Better understanding of pain management will lead to a decrease in pain and an increase in quality of life.

A. Target Population: All members who report pain, have a history of chronic pain and/or have conditions associated with pain.

B. Goal of Review:

I.   To discover whether there is a system in place to ensure that:
   1. a standard of practice in pain management exists
   2. a standard pain assessment and follow up protocol is available
   3. all members are screened for the presence of pain, particularly chronic pain, upon intake and periodically
   4. those members who report pain are adequately assessed
   5. members are involved in assessment of pain
   6. adequate follow-up for pain is documented

7. those members with cognitive impairments, nonverbal pain behavior, and/or vocalization of pain are identified and assessed (e.g., changes in gait, withdrawn or agitated behavior, moaning, groaning or crying);
8. caregivers of members with cognitive impairments are consulted about pain of the member
9. pain management plans are documented, evaluated, and revised as needed
10. treatment plans are followed up on and re-evaluated periodically.

II.   To discover whether the system works effectively by showing evidence of the following[1]:

-Program staff are trained to assess pain, to make referrals, and to follow up and evaluate pain management interventions on an ongoing basis

-All members are given repeated opportunities to report pain

-All members who report pain, who have conditions associated with pain, or who have a history of pain *have had a thorough pain assessment which is documented in their ISP*

-Pain assessments are followed by interventions that minimize or eliminate pain

-Pain management interventions suggested or implemented are consistent with state of the art practice, discussed with the member, and are not disruptive to member quality of life

-Side-effects of pain management (constipation, fatigue, altered mentation, hypotension) are adequately anticipated and evaluated with the member on an ongoing basis

-Members on a pain management plan are reassessed regularly for improvement, deterioration, or side-effects attributable to treatment. Reassessments include:
    -evaluation of significant issues identified in the initial evaluation
    -utilization of the same assessment scales for follow-up assessments
    -evaluation of analgesic medication use, side effects, and adherence problems
    -evaluation of the positive and negative effects of any treatment regime

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[1] Adapted from the Clinical Practice Guidelines developed by the American Geriatrics Society, 1998

-Members and their caregivers are consistently included/involved in the assessment of pain <u>and</u> in the evaluations of the effectiveness of pain management strategies

C. Data Sources. Sources of data should include, but are not limited to:

-ISP review: there is evidence in the chart of follow-through and successful referrals and interventions. Any failed pain management strategies have led to further action/referral….
-Relevant policies and procedures, in-services, provider competencies
-Member/caregiver/care team interviews

Recommended Pain Management Reading:

"Building an Institutional Commitment to Pain Management", The Wisconsin Resource Manual for Improvement. Wisconsin Cancer Pain Initiative, University of Wisconsin, Madison. 1996. For copies, call 1-608-262-0978. *This resource book provides a process for institutionalizing pain management including how to analyze current pain management practices in your care setting and how to develop and implement a pain management standard of practice.*

Pain Assessment and Treatment – Discussion Paper, University of Wisconsin-Madison Medical School **(attached)**. For additional copies, please call Patricia Berry at 608-262-0978. *This is a brief review, with full citations, of current pain and pain management literature.*

Clinical Practice Guidelines: *The Management of Chronic Pain in Older Persons.* Developed by the American Geriatrics Society Panel on Chronic Pain on Older Persons, 1998. **(attached)**